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Connecticut State Medical Society
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Connecticut State Medical Society
Testimony in Support of Senate Bill 959 An Act Concerning External Appeals of Adverse Determination By A Managed Care Organization, Health Insurer or Utilization Review Company
Insurance and Real Estate Committee
February 24, 2009

Senate Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Matthew Katz and I am the Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 members thank you for the opportunity to present this testimony to you today in support of Senate Bill 959 An Act Concerning External Appeals of Adverse Determination By A Managed Care Organization, Health Insurer or Utilization Review Company. This bill provides expanded benefits to consumers while improving transparency, and contracting and performance oversight of third-party administrators. CSMS believes that this bill provides physicians with the necessary tools to advocate for their patient's medically necessary care when a health insurer or other entity initially denies such medical care. A physician's determination of what is and is not medically necessary is paramount to ensuring quality patient medical care.

The bill creates a new definition for "adverse determination" which states as follows:

> A determination by a managed care organization, health insurer or utilization review company that an admission, service, procedure or extension of stay that is a covered benefit has been reviewed and, based on the information provided, does not meet the managed care organization's, health insurer's or utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and such requested, or payment for such, admission, service, procedure or extension of stay has been denied, reduced or terminated.

Under the current law, an enrollee (or a provider acting on behalf of an enrollee) who has exhausted all internal appeal mechanisms, may appeal an adverse determination to the commissioner within sixty days after receiving written notice of such determination. Upon receipt of an appeal, the commissioner shall assign the appeal for review to a review entity. The current law also permits the commissioner, after receiving three or more appeals of denials or determinations by the same managed care organization or utilization review company with respect to the same procedural or diagnostic coding, to issue an order specifying how such company shall make determinations about such procedural diagnostic coding.

This bill requires the managed care organization, health insurer or utilization review company, not later than five days after receipt of notification by the commissioner of the appeal, to provide to the review entity all documents and information that were considered in making the adverse determination.

The bill would permit an enrollee (or a provider acting on behalf of an enrollee) to petition the commissioner for an *expedited* external appeal at the time the enrollee receives an adverse determination provided that certain enumerated conditions set forth in the bill have been met. The bill further provides that, upon receipt of a request for an expedited external appeal and all required documentation, the commissioner shall immediately assign the appeal for review to a review entity. The review entity must conduct a preliminary review of the appeal not later than two business days after receipt of such appeal from the commissioner.

If the review entity accepts the appeal for review, such review must be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. Having a provider who specializes in the care being provided or attempting to be provided is critical in making sure that the patient's medical needs are considered and the specific medical care is appropriately considered and evaluated. The bill further requires the review entity to complete its full review of an expedited appeal not later than two business days after the completion of its preliminary review and shall forward its decision to the commissioner.

The managed care organization, health insurer or utilization review company, not later than one business day after receiving notice from the commissioner of the receipt of a request for an expedited external appeal, shall provide to the assigned review company all documents and information that were considered in making the adverse determination.

Under the proposed bill, the commissioner shall assign review entities to appeals on a random basis and shall choose such entities from among those approved by the Insurance Commissioner, after consultation with the Commissioner of Public Health. We believe that this provides a further layer of protection and prevents any potential conflicts of interest.

The bill also sets forth the eligibility requirements for approval by the commissioner and provides that each approval shall be effective for two years, unless the commissioner determines before its expiration that the review entity is not satisfying the minimum qualifications set forth in this bill. This is an important provision in the proposed bill.

Finally, CSMS supports the principle of minimum qualifications for each clinical reviewer assigned by a review entity to conduct external appeals as set forth in this bill. For example, the clinical reviewer must be an expert in the treatment of the enrollee's medical condition that is the subject of the external appeal.

Thank you for the opportunity to provide this information to you today. Please support Senate Bill 959.